SUGAR LAND
neuropsychology

Angela Larery, Ph.D.
Clinical Neuropsychologist/Psychologist

Authorization for Use and Disclosure of Health Information

Printed Name of Individual ____________ Birth Date ____________ Phone Number ____________

Street Address ____________ City, State, Zip Code ____________

I, the undersigned, hereby AUTHORIZE:	Angela Larery, Ph.D. Sugar Land Neuropsychology 12603 Southwest Fwy; Ste. 626 Stafford, TX 77477	713-900-5557 (p) 713-489-2030 (f)
TO FORWARD RECORDS TO:		

Information To Be Received/Disclosed: (Check *all* records you are requesting)

Behavioral Health Records
Developmental Disabilities Documentation
Other (Please Specify):

Further Medical Care
Eligibility / Benefits
RAW test data (RAW data will ONLY be released to LICENSED NEUROPSYCHOLGISTS)

Purpose of Disclosure: (Check all applicable categories)

Request By Patient
Other (Please Specify):

-

Your Rights with Respect to this Authorization

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to **Sugar Land Neuropsychology, 12603 Southwest Fwy, Ste. 626, Stafford, TX 77477**. I am aware that my withdrawal will not be effective until actually received by Sugar Land Neuropsychology and will not be effective, regarding the uses and/or disclosures of my health information that Sugar Land Neuropsychology has made prior to receipt of my withdrawal statement and in reliance upon this Authorization. I understand if the Authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by any Privacy Regulation. I understand that I do not have to sign this Authorization in order to receive treatment from Sugar Land Neuropsychology. I have the right to refuse to sign this Authorization unless the health services I am receiving are to determine benefits or employment status. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.
Authorization must be re-obtained on __________________ (date not to exceed 2 years). Include Expiration Date: _______________

SIGNATURE of Patient or Personal Representative ____________ Date ____________

PRINTED Name of Patient or Personal Representative ____________ Relationship to Patient ____________

Angela Larery, PhD
Employee Signature ____________ Date ____________

Angela Larery, Ph.D.
Printed Name of Employee

A signed copy of this form shall be considered effective and valid as the original.

Fees/charges will comply with all laws and regulations of release of Protected Health Information. Payment may be due prior to release.